D. Factor 4 is the disproportionate share adjustor. An adjustment for approved disproportionate share hospitals as determined by the D.C. Title XIX Single State Agency shall be applied. The disproportionate share adjustor shall be the lesser of: (a) the DSP adjustment factor as determined by the D.C. Title XIX Single State Agency; or (b) the minimum payment amount required by federal law. For example, if the D.C. Medicaid DSP for a hospital is 2.3% factor 4 under this methodology will be 1.023.

E. In no case shall the MMAP pay more than charges. Thus, the percent of charges paid shall not be greater than 1.000.

F. Payment for administrative days will be according to: (a) a projected average Medicaid nursing home payment rate; or (b) if the hospital has a unit which is a skilled nursing facility, a rate which is the lesser of that described in (a), or the allowable costs in effect under Medicare for extended services provided to patients of the unit.

10. Payment for administrative days, for recipients awaiting discharge from a psychiatric hospital to a residential treatment center will be according to the average Medicaid residential treatment center payment rate.

11. The Department reimburses a residential treatment center the lesser of, the provider's usual and customary charge, the provider's per diem costs for covered services established in accordance with Medicare principles of reasonable costs reimbursement as described in 42 CFR 413, or $300 per day. The $300 per day will be up-dated annually by the Health Care Financing Administration's published federal fiscal year market basket increase percentage relating to hospitals excluded from the prospective payment system.

(12) A hospital whose rates have not been approved by the Health Services Cost Review Commission may be reimbursed a capitated rate for lead poisoning treatment services provided to designated recipients. This reimbursement methodology will start effective May 21, 1994 and will cease April 1, 1995.

Within a twelve month period the Medical Assistance Program had approximately $562,608 in expenditures for hospital lead poisoning treatment services for 36 different recipients. It was determined that of the 36 cases, approximately 83% of the cases had blood lead levels (BLL) between 35-49 µg/dl, 11% had BLL between 50-59 µg/dl and only 6% had BLL between 60-69 µg/dl. Approximately 20%, 50%, and 100%, respectfully, of the cases in each of the categories require repetition of chelation therapy. With this information rates for the three different ranges of blood lead levels were developed. Each rate is for all services rendered within one year, necessary to reduce the blood lead level to an acceptable level. Below, are the rates:

35-49 µg/dl	$14,000
50-59 µg/dl	$20,000
60-69 µg/dl	$30,000

Payment for drugs, effective July 1, 1981, shall be as follows:

a. The provider shall produce records to verify any charge to the Program upon request.

b. The provider shall bill all appropriate insurance carriers before requesting payment from the Department.

c. The provider shall submit a request for payment on a form designated by the Department.

d. The Department may return to the provider all invoices not properly completed.

e. The pharmacy provider shall charge the Program his usual and customary charge to the general public for similar prescriptions.

f. The physician or osteopath shall charge the Program his actual acquisition cost for drugs dispensed.

h. Determination of allowable cost:

(1) The Interchangeable Drug Cost (IDC) which is for multiple source drugs listed on the Program's Interchangeable Drug List, allowable cost shall be the lowest of:

(a) Maximum amount the Program will reimburse for selected, approved interchangeable multiple source drugs determined by:

(i) Reviewing the latest edition of the Maryland State Formulary to select approved drug products for inclusion on the list;

(ii) Ascertaining the availability of the product from two principal sources of supply, as determined in consultation with provider representatives;

(iii) Ascertaining the lowest cost from among the approved interchangeable multiple source products available from each source;

(iv) Selecting as the IDC the higher of these two costs.

NOTE: Maximum allowable costs will be reviewed and updated:

(aa) At least once every year,

(bb) Whenever there is an emergency recall by the Food and Drug Administration, or

(cc) Temporarily, if there is an acute shortage of supply from available sources.

(v) Ascertaining the lowest cost from among the approved interchangeable multiple source products available from each source;

(vi) Selection as the IDC the higher of these two costs.

(b) The Estimated Acquisition Cost (EAC) which is the Program's best estimate of the cost of a drug product based on the following criteria in order of selection;

(i) Wholesale Acquisition Cost (WAC) plus ten percent; or

(ii) Direct price plus ten percent if WAC is not available; or

(iii) Distributor's price plus ten percent if neither WAC nor direct price is available; or

(iv) Average Wholesale Price (AWP) less ten percent if WAC, direct price or distributor's price is not available.

(c) Federal Generic Upper Limit (FGUL) which is the upper limit of payment for a multiple source drug for which a specific maximum allowable cost has been established by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services;

(2) For all other prescribed drugs, and Schedule V cough preparations, the allowable cost shall be the EAC established by the Department, as described in (b) above.

(3) Not withstanding the provisions of (1) above, when a prescriber certifies in his own handwriting that, in his

judgement, a specific brand is medically necessary, the EAC of the specified brand shall be the allowable cost.

(4) For condoms dispensed by pharmacy providers, the allowable cost shall be the EAC established by the Department based upon the AWP of the lowest price products generally available.

(5) For covered over-the-counter drugs, except those specified in section i. below, allowable cost shall be based on the AWP of the item.

(6) For medical supplies and equipment, the allowable cost shall be based on the AWP of the item.

i. Payment for covered services to a pharmacy will be made as follows:

(1) Payment for legend drugs, Schedule V cough preparations, enteric coated aspirin, and oral ferrous sulfate products will be the lower of:

(a) The provider's charge according to section f above; or

(b) The allowable cost of the item in section h, above, plus a professional fee.

(2) Payment for over-the-counter drugs except for enteric coated aspirin, oral ferrous sulfate products, and chewable tablets of ferrous salts in combination as described shall be the lowest of:

(a) The provider's charge according to f, above; or

(b) The allowable cost plus 50 percent; or

(c) The allowable cost of the item in h, above; plus a professional fee.

(3) Payment for chewable tablets of ferrous salts when combined with Vitamin C, multivitamins, multivitamins with minerals or other minerals in the formulation for individuals under 12 years of age will be the lowest of:

(a) The provider's usual and customary charge. Payment shall be limited to prescriptions with a usual and customary charge of $10 or less for 100 tablets. Charges for other quantities shall be calculated at the same rate.

(b) The allowable cost plus 50 percent.

(c) The allowable cost plus a professional fee.

(4) Payment for condoms shall be the lower of the:

(a) Provider's usual and customary charge according to f, above, or

(b) The AWP of the lowest priced product generally available plus 50 percent.

(5) Co-payment is not required for condom orders.

(6) Payment for medical supplies and durable equipment shall be the lower of:

(a) The provider's charge according to f, above; or

(b) The upper limit established by the Department based upon the lowest price at which the product is generally available throughout the State.

(7) Recipient co-payment of $1 per order will be deducted from the payment where applicable in (1), (2), and (3) and (6) above.

(8) The Department may pay providers using an approved unit dose system on the basis of a daily or monthly dispensing fee per nursing home resident. The value of these fees may not be higher than the pharmacists' usual and customary charge to non-Medicaid patients for similar services. Payments to nursing facilities will not exceed, in the aggregate, the FGUL.

j. The professional fee is a variable fee based on the type of prescription and is $4.21 for all prescriptions except those that are compounded for home intravenous therapy which have a fee of $7.25.

k. Payment for covered services to a physician or osteopath shall be made as follows:

(1) Payment for legend drugs, Schedule V cough preparations, over-the-counter drugs including enteric coated aspirin and oral ferrous sulfate products shall be the lower of:

(a) The physician's or osteopath's charge according to g, above; or

(b) The allowable cost of the item in h. above.

(2) Recipient co-payment of $1 per order will be deducted from the payment where applicable.

l. Reimbursement to a licensed physician for dispensing covered drugs to Medicaid recipients will be on the same basis as reimbursement to a registered pharmacist, if:

(1) The physician dispenses drugs on a regular basis in the physician's office;

(2) The physician's office is not located withihn a 10 mile radius of a Medicaid participating pharmacy; and

(3) The Medical Assistance Program, after a consultation with the Board of Pharmacy, has verified that the physician is dispensing medication in accordance with accepted pharmacy standards.

m. Payment will be made only for drugs supplied by manufacturers that have a signed national agreement or an existing approved agreement with the State, as set forth in Attachment 3.1A.

n. The State will not pay for:

(1) Prescribed drugs as described in Attachment 3.1A, Prescribed Drugs, Limitations.

(2) Products that are not medically necessary or life sustaining or are essentially cosmetic in nature.